AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (X4) ID PROVIDERS PLAN OF CORPECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X4) ID PROVIDERS PLAN OF CORPECTION (X4) ID PROVIDERS PLAN OF CORPECTION		RS FOR MEDICARE	AND HUMAN SERVICES	45+	ツー10128117 F	NTED: 09/10/20 ORM APPROVE
STREET ADDRESS, CITY, STATE, ZIP CODE 508 MOSE DRIVE SPARTA, THIS SERIA EACH DEPOSITION SHOULD BE DEPOSITION SHOU			(X1) PROVIDER/SUPPLIED/OUR	(X2) MULT A. BUILDIN	IFLE CONSTRUCTION	3) DATE SURVEY
LIFE CARE CENTER OF SPARTA STREET ADDRESS, CITY, STATE, 2P CODE SIGNAMERY STATEMENT OF DEPICIENCIES PREFUL TAG SUMMARY STATEMENT OF DEPICIENCY MUST SEP PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING IMPORMATION) F 000 INITIAL COMMENTS An annual Recertification survey and complaint investigation survey and completed on September 5, 2013, at Life Care of Sparta. No deficiencies were cited related to the complaint investigation under 42 CFIR Part 493, Requirements for Long Tarm Care Facilities. F 157 As alto(b)(11) NOTIFY OF CHANGES SS=D (INJURY/DECLINE/ROOM, ETC) A facility must immedialely inform the resident; consult with the resident's physicial, and if known, nolify the resident's legal representative or an interested family member when there is an accident involving the resident change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications), a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in \$483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or regomence as segment as specified in \$493.15(g)(2); or a change in resident rights under Federal or State law or regulations as a specified in paragraph (b)(1) of this section. The facility must record and periodically update	NAME OF	PROVIDER OR SUPPLIED	445421	B. WING		4
FOOD INITIAL COMMENTS An annual Recertification survey and complaint investigation #32346, were completed on September 5, 2013, at Life Care of Sparta. No deficiencies were cited related to the complaint investigation under 42 CFR Part 483, Requirements for Long Term Care Facilities. As 3.10(b)(11) NOTIFY OF CHANGES (INJURRY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; or interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician, intervention; a significant change in conditions); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment) due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in \$483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in \$483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in noon or roommete assignment as specified in \$483.12(a). The facility must record and periodically update	LIFE CA	RE CENTER OF SPAR			508 MOSE DRIVE	<u>09/05/2013</u>
F 000 INITIAL COMMENTS An annual Recertification survey and complaint investigation #32346, were completed on September 5, 2013, at Life Care of Sparta. No deficiencies were cited related to the complaint investigation under 42 CFR Part 483, Requirements for Long Term Care Facilities. ### 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's sphysicial, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. **The facility must record and periodically update** Ilife Care Center of Sparta is committed to upholding the highest standard of are for its residents. The facility respectfully works in cooperation with the selicity requirements. Fe 157 ### Intervention of continue of continue with the resident without the with the resident follows in	PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION DATE
	F 157 SS=D	An annual Recertific investigation #32346 September 5, 2013, deficiencies were citrivestigation under 4 Requirements for Lo 483.10(b)(11) NOTIFICATION (INJURY/DECLINE/F) A facility must immediate the resident involving the injury and has the polarity and the resident form of treatments and the facility must also produced in facility must also produced in facility must also produced in §483.12(a). The facility must also produced in §483.15(e) esident rights under Facility must also produced in §483.15(e) esident rights under Facility in the resident r	cation survey and complaint it, were completed on at Life Care of Sparta. No ed related to the complaint it? CFR Part 483, and Term Care Facilities. It? OF CHANGES ROOM, ETC) liately inform the resident; ent's physician; and if dent's legal representative by member when there is an esident which results in ential for requiring physician eant change in the resident's sychosocial status (i.e., a mental, or psychosocial eatening conditions or it a need to alter treatment ed to discontinue and the due to adverse commence a new form of on to transfer or discharge acility as specified in promptly notify the resident dent's legal representative ember when there is a mate assignment as (22); or a change in ederal or State law or discontinue and ederal or State law or discontinue and ederal or State law or discontinue and the paragraph (b)(1) of		Life Care Center of Sparta is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of Tennessee Department of Health toward the best interest of those who require the services we provide. While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted September 3-5, 2013. This Plan of Correction is the facility's allegation of substantial compliant with Federal and State requirements. F157 1. Resident #46 was discharged prior to survey. 2. a) All residents who had significant change in condition were audited by Director of Nursing /Assistant Director of Nursing by September 20, 2013. b) No other residents who had a significant change in condition were affected by the alleged deficient practice. 3. a) The Staff Development Coordinator will educate 100% of licensed nurses by September 27, 2013 regarding timely notification of	9/20/2013
				İ	physician when a significant change in a	

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are dited, an approved plan of correction is requisite to continued

FORM GMS-2567(02-95) Previous Vorsions Obsolete

Event ID: Q5R\$11

Facility ID: TN9301

If continuation sheet Page 1 of 13

STATEME	NT OF DEFICIENCIES	(X4) PROMPERIOR				0	MR NO	. 0938-03
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MŲ: A. BUILO	LTIP	PLE CONSTRUCTION	<u> </u>	(X3) DAT	. 0938-03: E SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	445421	B, WING	·	<u> </u>		!	
	ARE CENTER OF SPAF	RTA		5	STREET ADDRESS, CITY, STATE, ZIP 508 MOSE DRIVE	CODE	09/	05/2013
(X4) ID	Ctil Dagues]		SPARTA, TN 38583			
PREFIX	(EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N CUALIFIE	86	(XS) COMPLETION DATE
	the address and pholegal representative This REQUIREMENT by: Based on medical rethe facility failed to no significant changes in for one resident of two reviewed. The findings included Resident #46 was ad 16, 2013, with diagnoon Renal Disease, Rena Airway Obstruction, Hollitus, Peripheral Voosteomylitis of the Le Medical record reviewed August 17, 2013, at 8: Entry for 8-17-13 @ (attering the res.'s (restaminister) am (mornand check BS (blood she unresponsiveche OW (Equal to or belouitizedVital signs ter pulse 32/min (thiry two Rate 22/min (Respirate minute) Blood Presided in the condition and Emergency Medical St. 25:40 am and FMT (Fig. 18).	or interested family member. T is not met as evidenced ecord review and interview, offy the physician timely of a resident's (#46) condition renty-nine residents It is most met as evidenced ecord review and interview, offy the physician timely of a resident's (#46) condition renty-nine residents It is most met as evidenced it is a resident's (#46) condition renty-nine residents It is not met as evidenced it is a resident's (#46) condition renty-nine residents It is not met as evidenced it is a resident's notion. Diabetes ascular Disease, fit Ankle, and Infection. I of the Nursing Notes dated it is a resident's room to adm. It is a resident to cked BS -meter reading it is a resident to cked BS -mete	F1			view nurses who has significate audit for audi	sing ave ant or or office fit see, ad,	

PRINTED: 09/10/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	CV214##	Tipl	OMB	VO. 0938-03
	·	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) t	DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	445421	B. WING	_	1	
	RE CENTER OF SPAI			STREET ADDRESS, CITY, STATE, ZIP CODE 508 MOSE DRIVE		9/05/2013
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		SPARTA, TN 38583		
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	VIII	(X5) COMPLETION DATE
F 157	Continued From pares to be without pu	ge 2 Ise and respiration"	F 15	57		
	Medical record revies Sheet dated August patient 8/17/2013 5: was found unrespond respirationstaken to (without electrical actions) 19:49:00 in 3 leads	ew of the County EMS Run 17, 2013, revealed "Arrived 44:00 Notes (Notes 1)				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Medical record review Hospital Transfer For revealed the resident "hospital, with vital pulse of 32, respirato	w of the Nursing Home to rm, undated and untimed t was transferred to the signs of temperature of 99.3, by rate of 22 and an oxygen				
tt s v r c b w F 282 4	he resident was "very tage renal disease, oveekly, and the facility esident but could not all. The Physician co e informed immediaty were 32 beats per mir	CES BY OUALIERS	F 282	F282		
ac	DAG DADIAGIO DA D	or arranged by the facility ualified persons in resident's written plan of		Padding was added to Resider side rails on September 03, 2013 working with Resident #36 were immediately educated on Septem 23, 2013 by April 1987.	3. Staff	9/03/2013
Th		is not met as evidenced		03, 2013 by Assistant Director of Nursing that Resident #36 should padded side rails at all times.	i have	

PRINTED: 09/10/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	(XI) PROVIDED SERVICES			FUK!	M APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION VG	(X3) DA	D. 0938-039 TE SURVEY IMPLETED
NAME OF	PROVIDED OF	445421	B. WING		ĺ	
	PROVIDER OR SUPPLIER ARE CENTER OF SPAI			STREET ADDRESS, CITY, STATE, ZIP C	ODE 08	8/05/2013
(X4) (D	SUMMARY STA	TEMENT OF DEFICIENCIES		SPARTA, TN 38583		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	CUM14 =	(X5) COMPLETION DATE
ti a b ti a b ti a b ti a b ti a c c c c c c c c c c c c c c c c c c	by: Based on medical rand interview, the far plan for padded sides of twenty-nine reside. The findings include: Resident #36 was acted. A 2012, and readm October 8, 2012, with Congestive Heart Facardiac Pacemaker, Pulmonary Disease, Insomnia, Aortic Valve Depressive Disorder. Observation on Septement's areas to the top of bookine of the observation reas "were normal worm and will bruise." In the resident was on an observation on Septement of the resident in the bevealed the side rail worther observation readded. edical record review hysician's Recapitula sident was receiving nti-coagulant medicat	decord review, observation, collity failed to follow the care reals for one resident (#36) ents reviewed. d: Imitted to the facility on July litted to the facility on a diagnoses including liture, Atrial Fibrillation, Chronic Obstructive Peripheral Vascular Disease, to Disorder, Anemia, and ember 3, 2013, at 12:26 froom revealed bruised th hands. Interview at the n revealed the bruised rear and tear, if it gets Further interview revealed inti-coagulant medication. Imber 3, 2013, at 3:03 p.m., and in the resident's room was in the raised position. In the resident's room was in the raised position. Of the August 2013 tion Orders revealed the Coumadin, an ion.	F 28	DEFICIENCY)	lursing /care / 2013. h padded he alleged 0% of i nursing ent's care ing side rail /Minimum idents planned to mpliance simum Data	9/03/2013
;	eview of the Care Pla of updated on July 10 alteration in skin inte	n dated February 6, 2013, l, 2013, revealed "at risk grity due to impaired	.			

STATEME		& MEDICAID SERVICES	_		FOR	M APPROV	Æ
AND FLAN	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IFFE CONSTRUCTION		D. 0938-0: TE SURVEY	
			7 11 DOJEDAN			MPLETED	
NAME OF	F PROVIDER OR SUPPLIER	445421	B. WING	·	1		
			T	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/05/2013	_
	ARE CENTER OF SPAR	RTA		508 MOSE DRIVE			
(X4) ID		TEMENT OF DEFICIENCIES		SPARTA, TN 38583			
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F 282	Continued From pag	76 A				 	_
	mobility, incontinence	o and ups of	F 282	b) The Performance improveme	nt	İ	
	iniegicatiouVbbBC	MCHES: 7MBM2 - Ja	}	Committee consisting of Executive	2	1	
	padding to side rail			Director, Director of Nursing, Med	lical		
	Intonious with the A.			Director, Director of Rehabilitation	n		-
	On September 5, 201	sistant Director of Nursing, 3, at 8:55 a.m., in the		Director of Health Information, Di	rector		
	LICENCE S LUCID MODE	fmod the state	i	of Clinical Nutrition, Director of	125(0)		
j	Leadaca, I Millish Illis	MICH CAMBERS AT IL - 4		Maintenance, Director of	ľ		1
	had failed to follow the side rails.	e Care Plan for the padded		Environmental Services, Business (Office		-
F 315			j	Manager, Director of Recreational	June		ľ
SS=D	RESTORE BLADDER	TER, PREVENT UTI,	F 315	Services, and Staff Development			ſ
			ļ ¦	Coordinator will review results. If i	+ in		1
ļ	Based on the residen	t's comprehensive	. }	deemed necessary by the committ	E IS		ı
	geogestinent, the facili	It must specied that a	[additional education may be provide	ee,		1
j	resident who enters the	ne facility without an not catheterized unless the		the process evaluated/revised, and	rea,	•	1
į.		7371000 7102222224		the audits reviewed for 3 months of	or		ı
	PANIEKEI MARIONI WAS DE	300000000 000 =		until 100% compliance is achieved.			ľ
ļ,	treatment and service	s to prevent wis-		F315			
	function as possible.	re as much normal bladder	İ	1. The Director of Nursing educated			ı
1				Licensed Practical Nurse that did no	tine ;	/16/2000	l
].	This DEAL NAME			complete catheter Justification on	iτ .∫³	/16/2013	l
) _F	TAIS REQUIREMENT	is not met as evidenced	!	facility's policy on ***********************************	. ·		l
1 7	~g.	ord review, review of facility	1	facility's policy on completion of fol	ey '	•	l
(P	CANANI GILM HINGINGW. II	18 TSCility foiled to Louis		catheter justification worksheet on			l
13,	acompation for the list	DI 20 (DAMANI)		September 16, 2013.			
, ,	or one resident (#26) : eviewed.	of twenty-nine residents	!		-	j	
	cvieweg,			2. a) The Assistant Director of Nursi	ne		
T	he findings included:		-[audited 100% of residents with fole	, 9/	/04/2013	ı
1	-			catheters on September 04, 2013.	′		
ļ R	Resident #26 was adm	itted to the facility on May		•	ĺ	ſ	
-	S, GV 12, AND LEBORNING	of to the facilities	į	b)No other residents with foley	1	j	
1.	ebruary 14, 2013, with	diagnoses including		catheters were affected by the alleg	ed	·	
CMS-2567/	/A2 DRI D			deficient practice.		Ī	

STARTON	CINS FOR MEDICARI	E & MEDICAID SERVICES			בעווען בּו	D: 09/10/201
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OUR	2000		OMB NO	MAPPROVE D. 0938-039
	- DOI WILL HON	IDENTIFICATION NUMBER;	Y BRITOIN	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
NAME OF	PROVIDED	445421	B. WING	, 	-	
	PROVIDER OR SUPPLIER			STREET ARREST	09	/05/2013 »
LIFE C	ARE CENTER OF SPAR	ATS.	- 1	STREET ADDRESS, CITY, STATE, ZIP CODE 508 MOSE DRIVE		
(X4) ID				SPARTA, TN 38583		
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TAG		MOST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
F 315	T - A . INDIA DAG	ge 5 ·			i	
	Congestive Heart Fo	siluro Aitannel Santa	F 315	i viic ocall Developitient		Į į
			1	Coordinator will educate 100%	nf :	j .
			}	licensed nurses on following fac	ilitarle	
j				policy on foley catheters by Sep	linty S .	
	Psychosis, Insomnia Atherosclerosis.	alignant Neoplasm of Breast, , and Coronary		27, 2013.	ember.	
ĺ		٠,	ļ	b) The Director of Nursing/As		1
1	Medical record review	w of a Physician Telephone		Director of Nursing will audit res	inr	ľ
[1	with foley catheters weekly for	idents !	j
	III ISELLTOIEV CATAD	ter indication diameter i		compliance for 3 months.	iÌ	J
İ	Comfort Measures"				1	J
ĺ	Review of facility palls			4. a) Director of Nursing/Assista	nt 🍴	.1
	revealed "Policy A ca	cy, Indwelling Catheters, ient who enters (named		Director of Nursing will present a	results	ļ
	ALITHOUT SALINA	WOULDO 004644		of audits to the Performance	34416	· · ·]
	THE PROPERTY OF THE PROPERTY O	IP OBCCOO's allalant and a		Improvement Committee.		1
		NOTONZONAK IS		:	!	
	iecessarv…intent A	n incheolist and the contract of the contract	•	b) The Performance Improvem	ent I	ļ
		ere is a valid medical res: 3. b. Insert urinary	•	Committee consisting of Executive	e i	
	THE PROPERTY OF THE PROPERTY OF THE	TITION modicals	!	Director, Director of Nursing, Med	fical	- 1
, ,	いっちょさい ハム いはら さはないせい	NO bitualista a la la la la la la la la la la la la	J	Director, Director of Rehabilitation	, !	,
				Director of Health Information, Di	rocke-	']
			1	of Clinical Nutrition, Director of	ierror!	- }
	'Y'Y'UUIIGIII (II IIFINSK	//DAAA4		Maintenance, Director of	ĺ	
1 -	. A	er. A comprehensive clude: a. The risks and],	1
, ~	Circing Of all Indimeller	M cotholog - f- :	ł	Environmental Services, Business	Office	
1 -	abbarnia medical me	ITICONON for the table to		Manager, Director of Recreational	j	
ļ a:	nd continuing need for	r the catheter use"	ļ	Services, and Staff Development	ļ	
		l l		Coordinator will review results. If	t is	1
ar	nd Licensed Processor	num Data Set Coordinator		deemed necessary by the committee	ee,	
,	- vira station on stant	Nurse #3, at the Orchid ember 4, 2013, at 3:24	!	additional education may be provi	ded. †	
-	'''-, YVIIIIIIIIIII MEU MIR TOIR	WC9thatasiana !		the process evaluated/revised, and	d or	j
0.	' YYYY 20, 2013, 200 M	1の 1のたけは トムム ギーリー・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	ĺ	the audits reviewed for 3 months	1 -	
~~	winders the calleter a	Secondari C	i	until 100% compliance is achieved		· .
111	terview confirmed the	facility did not have	į.			}

からいで	NT OF DEFICIENCIES	ON PROVINCES			O.		APPROV	¢
OND FLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DAT	. 0938-03 E SURVEY PLETED	9
NAME OF	PROVIDER OR SUPPLIER	445421	B. WING		-			
	RE CENTER OF SPAR	RTA		STREET ACORESS, CITY, STATE, ZII 508 MOSE DRIVE SPARTA, TN 38583	PCODE	<u>09/0</u>	05/2013	_
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T m for st	medical justification the time of the insert facility had failed to facility had failed to facility had failed to facility had failed to facility had failed to for the facility must possed a daily basis: o Facility name. o The current date. o The current date. o The total number at by the following category unlicensed nursing stresident care per shift. Registered nurses (as a continual nurses (as continual nurses (as continual nurses as the facility must post of each shift. Data must post in a prominent place esidents and visitors. The facility must, upon the facility must, upon the facility must, and the facility must maintain the f	for the use of the catheter at ion on July 23, 2013, and the ollow the facility policy. NURSE STAFFING If the following information on the factual hours worked pries of licensed and aff directly responsible for the second defined under State law). It is nurses or licensed defined under State law). It is nurse staffing data daily basis at the beginning lest be posted as follows: I readily accessible to I oral or written request, at available to the public to exceed the community.	F 315	5	mation was september rdinator wi nurses that fon must be eard at ordinator sed nurses mation must board at tember 27 /Assistant lit for ek for 3	03, 1	9/03/2013	

DEF _CEN	ARTMENT OF HEALTH	AND HUMAN SERVICES		P	RINTED: 09/10/2013
STATE! AND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION O	FORM APPROVED MB NO. 0938-0391
ļ		445421	- 1	YG	COMPLETED
1	OF PROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/05/2013
	CARE CENTER OF SPAR			508 MOSE DRIVE SPARTA, TN 38583	
(X4) (PREF TAG	X (EACH DESIGNAL	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 35	the current date. The findings included Observation on September and the Ass September 3, 2013, a date was not current. 483.35(i) FOOD PROSTORE/PREPARE/SITTHE facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, dissince of the current of the considered satisfactor authorities; and (2) Store, prepare, dissince of the current of the c	on and interview, the facility taffing information daily with the facility staffing information daily with the ember 3, 2013, at 9:35 a.m., vealed a Nurse Staffing other 1, 2013. Istant Director of Nursing on t 9:50 a.m., confirmed the CURE, ERVE - SANITARY sources approved or y by Federal, State or local or the confirmation.		Committee consisting of Executive Director, Director of Nursing, Medic Director, Director of Rehabilitation, Director of Health Information, Director of Clinical Nutrition, Director of Maintenance, Director of Environmental Services, Business Of Manager, Director of Recreational Services, and Staff Development Coordinator will review results month it is deemed necessary by the	cal ector ffice thly.
	This REQUIREMENT by:	is not met as evidenced and interview, the facility		1. The range top, grill, back splash, an can opener slot were immediately cleaned on September 03, 2013. 2. a) Maintenance Department removed the back splash and shelf from the kitchen to be sanded and pressure washed on September 13, 2013. The shelf will not be replaced in kitchen.	um l
	Observation on Septem and interview with the D	ber 3, 2013, at 2:30 p.m., letary Manager present	,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 09/10/2013 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING _ COMPLETED 445421 B. WING NAME OF PROVIDER OR SUPPLIER 09/05/2013 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF SPARTA 508 MOSE DRIVE SPARTA, TN 38583 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE PREFIX (XB) COMPLETION TAG DVLE DEFICIENCY) F 371 Continued From page 8 F 371 during the observation confirmed the following: b) Dietary associates will wipe up spills as they occur on the range top and grill. 1.)The range top, back splash and shelf had an Each evening, dietary associates will accumulation of blackened debris. 2.) The grill, connected to the range top, had an clean cast iron grates, burner area, grill, accumulation of blackened debris. and back splash to remove any 3.) The can opener slot had sticky blackened blackened debris accumulated. debris present. F 431 483.60(b), (d), (e) DRUG RECORDS, c) On September 16, 2013, a LABEL/STORE DRUGS & BIOLOGICALS F 431 9/19/2013 \$5≈D replacement can opener and base was ordered and was installed by the The facility must employ or obtain the services of a licensed pharmacist who establishes a system Maintenance Department on of records of receipt and disposition of all September 19, 2013. Dietary associates controlled drugs in sufficient detail to enable an will clean can opener slot after each accurate reconciliation; and determines that drug meal to remove any blackened debris records are in order and that an account of all controlled drugs is maintained and periodically accumulated. reconciled. 3. a) Dietary Manager will in-service Drugs and biologicals used in the facility must be 100% of dietary associates on cleaning labeled in accordance with currently accepted schedule and the importance of professional principles, and include the maintaining sanitary dietary equipment, appropriate accessory and cautionary instructions, and the expiration date when by September 27 2013. applicable. b) Dietary Manager/ Director of In accordance with State and Federal laws, the Nutritional Services will audit sanitation facility must store all drugs and biologicals in of range top, grill, back splash, and can locked compartments under proper temperature controls, and permit only authorized personnel to opener slot five times per week for 3 have access to the keys. months. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to

PRINTED: 09/10/2013

ND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	OMB N	MAPPROV 0. 0938-03
		AND THE PARTY OF T	A. BUILDIN	\$	(X3) DA	TE SURVEY
AME OF	PROVIDER OR SUPPLIER	445421	B, WING	_ _ _		
				STREET ADDRESS, CITY, STATE, ZIP CODE	09	/05/2013
	ARE CENTER OF SPAR	RTA	- 1	508 MOSE DRIVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		SPARTA, TN 38583		
TAG	(EACH DEFICIENCY REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECT	TION	1 1100
		DENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)		COMPLETING DATE
F 431	1 - 4. W. 1000 1 1011 DSU	je 9				
j	fabuse, except when	the feether.	F 431	1 A maniferrance pepartitions	will	
	package drug distrib	utler racility uses single unit		inspect the range top, grill, back	grill, back splash.	
	be readily detected.			and can opener slot monthly to	monitor	
	to toppiny delected.			for any additional preventative		
			ļ	maintenance needs. Director of	•	
	This REOLUBEAGE			Maintenance/ Maintenance asso	ociate	
	ph:	is not met as evidenced		will report any needs for preven	tative	
- 1	Based on observation	n, review of facility policy		maintenance to the Executive Di	rector.	
-			1	Dietary Manager, and Assisted Li	ving (
	MANAGE MEDICAMA	on vials were properly stored cation carts reviewed.	ĺ	Coordinator.		
í	The findings included:		}	4. a) The Dietary Manager/Direct	orof	
í		1		Nutritional Services will report re	sults	
· [Observation on Septe	ion on September 5, 2013, at 10:40		from audits to the Performance		
			[Improvement Committee.		
	the Orchid nursing sta multi-dose vial of injection	COD FOUNDATED		h) The Darfe was tree		
	pened, undated, and	Without a label		b) The Performance Improveme		
				Committee consisting of Executive Director, Director of Nursing, Med	,	
"	THE VIEW WITH LICENSE	Practical Nurse (LPN) #1,		Director, Director of Rehabilitatio		
'n	nedication cart at the	Droblet		Director of Health Information, Di		
	יותם-ווועונון פווו שטיייועסט	se vial of Lidocaine was			rector	
٥	pen and unlabeled.]	of Clinical Nutrition, Director of Maintenance, Director of	1	
IR	eview of facility policy		ļ	Environmental Services, Business	Office	
		, Accessing a Multi-Dose	İ	Manager, Director of Recreationa		
	··· QUIVANCE The tacilit	trendi manada a di di	j	— ·	'	
16.		910 6164	-	Services, and Staff Development Coordinator will review results. If		
	e labeled, after openin		-			
па	medate and time	y, withresident's	1	deemed necessary by the commit		[
Via	als are to be discarded	ifopen and undated"	ļ	additional education may be prov		ł
		I I		the process evaluated/revised and		
(A	DON) in the ADOM:-	ant Director of Nursing office on September 5,	}	the audits reviewed for 3 months	or ·	1
	N at the ADOMS (mice on September 5,	Ì	until 100% compliance achieved.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 09/10/2013 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED 445421 NAME OF PROVIDER OR SUPPLIER B, WING 09/05/2013 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF SPARTA 508 MOSE DRIVE SPARTA, TN 38583 (X4) (D PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL D PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION DATE TAG DEFICIENCY) F 431 Continued From page 10 2013, at 1:40 p.m., confirmed the Lidocaine F 431 F431 multi-dose vials come from the pharmacy without .1. The multi dose vial was removed a patient label. The ADON also confirmed, that per facility policy, the vial should have a label of from the medication cart and discarded 9/05/2013 date, time opened, and label for the resident it on September 05, 2013. was used for. F 441 483.65 INFECTION CONTROL, PREVENT 2. a)The Assistant Director of Nursing SPREAD, LINENS F 441 SS=E audited 100% of facility's medication 9/05/2013 carts on September 05, 2013 and found The facility must establish and maintain an Infection Control Program designed to provide a no other opened multi dose vials safe, sanitary and comfortable environment and without a label or date. to help prevent the development and transmission of disease and infection. b) No resident receiving medications from a multi dose medication vial were (a) Infection Control Program affected by the alleged deficient The facility must establish an Infection Control Program under which it practice. (1) Investigates, controls, and prevents infections in the facility; 3. a) The Staff Development (2) Decides what procedures, such as isolation, Coordinator will educate 100% of should be applied to an individual resident; and licensed nurses on (3) Maintains a record of incidents and corrective dating/labeling/initialing multi dose actions related to infections. medication vials by September 27, (b) Preventing Spread of Infection .2013. (1) When the Infection Control Program determines that a resident needs isolation to b) The Director of Nursing/Assistant prevent the spread of infection, the facility must Director of Nursing will audit the isolate the resident. medication carts weekly for compliance (2) The facility must prohibit employees with a communicable disease or infected skin lesions for 3 months. from direct contact with residents or their food, if direct contact will transmit the disease. 4. a) The Director of Nursing/Assistant (3) The facility must require staff to wash their hands after each direct resident contact for which Director of Nursing will present results hand washing is indicated by accepted of audits to the Performance professional practice. Improvement Committee.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEMEN	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			FORM APPR MB NO. 0938	
10 FEAIN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	AND COMMENTAL PROCESSION	(X3) DATE SURVE	
AME OF	PROVIDER OR SUPPLIER	445421	8. WING			
				STREET ADDRESS, CITY, STATE, ZIP CODE	09/05/201	
IFE CA	RE CENTER OF SPAI	RTA	- 1	508 MOSE DRIVE		
(X4) (D	SUMMODY 61	TTPL 450		SPARTA, TN 38583		
REFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	(GI	PROMISEUS DI AMISE CAN		
	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLE ATE CAT	
441	Continued From pa	ge 11	<u> </u>			
	•		F 44	,	it ¦	
	(c) Linens			Committee consisting of Executive	1	
i	Personnel must han	ndle, store, process and	ł	Director, Director of Nursing, Medic	al	
	infection.	as to prevent the spread of		Director, Director of Rehabilitation,	- }	
	" " " " " " " " " " " " " " " " " " "			Director of Health Information, Dire	ctor	
		ľ		of Clinical Nutrition, Director of	ĺ	
	~			Maintenance, Director of	.1	
- 1	inis REQUIREMEN by:	T is not met as evidenced		Environmental Services, Business Of	ffice	
				Manager, Director of Recreational		
		on and interview, the facility lines to prevent the spread of		Services, and Staff Development	- 1	
1 -		Out of twenty-seven		Coordinator will review results. If it	le İ	
. '	residents.	and a dovern		deemed necessary by the committee	1	
13	The findings included	. }		additional education may be provide	4	
, 1	The midnigs MGIDDEO	·		the process evaluated/revised, and		
C	Observation on Septe	ember 3, 2013, at 12:00		the audits reviewed for 3 months or		
	III NIE MAN DIUI			until 100% compliance is achieved.	1	
Tr.	evealed the Certified	Nursing Assistant Court III		F441		
5	Cooped the ice soul	pp from the ice chest,	f	1.The ice cooler and scoop were	9/03/201	
1 7 5	SOUGHIS WHITE MIN A	Order	1	immediately cleaned and all staff in		
			}	dining area were educated on how to	.	
			.	appropriately distribute ice from the	ion	
	ining room.	isidents served in the main		cooler and store the ice scoop by	ire	
i			1	Dietary Manager on September 03,		
In	terview with CNA #1	on September 3, 2013, at	ł	2013.	}	
					1	
				2. a) The ice cooler and scoop were	9/03/2013	
7 7 10	terview with CNA #1	confirmed "this is	1	immediately cleaned and all staff in	-,05,2013	
1.		ŀ	}	dining area were educated on how to	J	
Int	erview with the Dieta	ary Manager on September	j	appropriately distribute ice from the ic		
				cooler and store the ice scoop by	e ¦	
	inition the ice scool	p was not to be stored in	ĺ	Dietary Manager on Sontonte and	1	

2013.

Dietary Manager on September 03,

STATEMENT OF DEFICIE! AND PLAN OF CORRECT!	VCIES (X	MEDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MLII	TIPLE CONSTRUCTION	OMB NO	
		WENT FICATION NUMBER:	A. BUILD	ING	(X3) DAT	TE SURVE MPLETED
NAME OF PROVIDER OR		445421	8. WING			
				STREET ADDRESS, CITY, STATE, ZIP CODE	09,	<u> 05/2</u> 013
LIFE CARE CENTER	OF SPARTA		j	508 MOSE DRIVE		
(X4) ID SU	MMARY STATES	ENT OF DEFICIENCIES		SPARTA, TN 38583		•
PREFIX (EACH) TAG REGULA	DEFICIENCY MU TORY OR LSC	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION JLD BE OPRIATE	(X5) COMPLET DATE
				b) No other residents were a	ffected	
			1	by the alleged deficient practice		
				ice cooler and ice scoop was clea	aned.	
!				3. The Staff Development Coor	dinator	
}				will educate 100% licensed nurs		
,			1	certified nursing assistants on in		
				control standards regarding dist		
				of ice from the ice cooler and	1	
				appropriate storage of the ice si September 27, 2013.	coop by	
				b) The Director of Nursing/Assi Director of Nursing will audit ice distribution and ice scoop storal practice for compliance weekly months.	ge	
				4. a) The Director of Nursing/As. Director of Nursing will present of audits to the Performance		
			i	Improvement Committee.	1	
j			1	b) The Performance Improver		
		1	ļ	Committee consisting of Executive		
į ·			!	Director, Director of Nursing, Me		
				Director, Director of Rehabilitation Director of Health Information, I		
			}	of Clinical Nutrition, Director of	vicectot.	
		ļ	-	Maintenance, Director of		
			1	Environmental Services, Business	Office	
			-	Manager, Director of Recreation		
1			1	Services, and Staff Development		
				Coordinator will review results. I		
		= · · · ·			· = · =	